AUTHORITY: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

SOURCE: 55 FR 23441, June 8, 1990, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes affecting this part appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

Subpart A—General Provisions

§ 414.1 Basis and scope.

This part implements the indicated provisions of the following sections of the Act:

1802—Rules for private contracts by Medicare beneficiaries.
1820—Rules for Medicare reimbursement for telehealth services.
1833—Rules for payment for most Part B services.
1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.
l848—Fee schedule for physician services.
1881(b)—Rules for payment for services to ESRD beneficiaries.
1887—Payment of charges for physician services to patients in providers.

[60 FR 50442, Sept. 29, 1995, as amended at 63 FR 58910, Nov. 2, 1998]

§ 414.2 Definitions.

As used in this part, unless the context indicates otherwise—

AA stands for anesthesiologist assistant.

AHPB stands for adjusted historical payment basis.

CF stands for conversion factor.

CRNA stands for certified registered nurse anesthetist.

CY stands for calendar year.

FY stands for fiscal year.

GAF stands for geographic adjustment factor.

GPCI stands for geographic practice cost index.

HCPCS stands for HCFA Common Procedure Coding System.

Physician services means the following services to the extent that they are covered by Medicare:

(1) Professional services of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors.

(2) Supplies and services covered ''incident to'' physician services (excluding drugs as specified in § 414.36).

(3) Outpatient physical and occupational therapy services if furnished by a person or an entity that is not a Medicare provider of services as defined in § 400.202 of this chapter.

(4) Diagnostic x-ray tests and other diagnostic tests (excluding diagnostic laboratory tests paid under the fee schedule established under section 1833(h) of the Act).

(5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

(6) Antigens, as described in section 1861(s)(2)(G) of the Act.

(7) Bone mass measurement.

RVU stands for relative value unit.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63686, Dec. 2, 1993; 59 FR 63463, Dec. 8, 1994; 60 FR 63177, Dec. 8, 1995; 63 FR 34328, June 24, 1998]

§ 414.4 Fee schedule areas.

(a) *General.* HCFA establishes physician fee schedule areas that generally conform to the geographic localities in existence before January 1, 1992.

(b) *Changes.* HCFA announces proposed changes to fee schedule areas in the FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, HCFA publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

Subpart B—Physicians and Other Practitioners

SOURCE: 56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, unless otherwise noted.

§ 414.20 Formula for computing fee schedule amounts.

(a) *Participating supplier.* The fee schedule amount for a participating supplier for a physician service as defined in § 414.2 is computed as the product of the following amounts:

(1) The RVUs for the service.

(2) The GAF for the fee schedule area.

(3) The CF.

(b) *Nonparticipating supplier.* The fee schedule amount for a nonparticipating